Informed Consent
Endodontic (Root Canal) Treatment

I, _____, have been made aware of my condition

_____requiring endodontic (root canal) treatment in the opinion of my dentist, Brian Mitchell DDS. I am aware that the practice of dentistry is not an exact science and no guarantees have been made to me concerning the results of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth.

I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/ or other systemic disease problems.

I understand that some complications of root canal treatment may be, but not limited to:

- Failure of the procedure, necessitating re-treatment, root surgery, or extraction.
- Post-operative pain, swelling, bruising, and/or restricted jaw opening that may persist for several days or longer.
- Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery by a specialist for removal.
- Perforation of the canal with instruments may require additional surgical treatment by a specialist or result in loss of the tooth.
- Damage to sinuses or nerves resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.

I understand the successful completion of a root canal procedure does not prevent future decay or fracture. I further understand that an endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chances of fracture.

I understand the recommended treatment, the fee(s) involved, the risks of treatment, any alternatives and risks of those alternatives, including the consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

Patient Signature: _____ Date: _____